MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08229

8228

CERTIFICATE OF DEATH

Reg. Dist. No. 355

1. PLACE OF DEATH:
COUNTY Worcester MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Whaleyville
LENGTH OF STAY (In this place) Life
HOSPITAL OR INSTITUTION OR STREET ADDRESS ✓

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Worcester
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Whaleyville
STREET ADDRESS (If rural, give location) ✓

3. NAME OF DECEASED: (Type or Print) (First) Margaret (Middle) Elizabeth (Last) Armstrong

4. DATE OF DEATH: (Month) Aug. (Day) 9 (Year) 1955

5. SEX: Female

6. COLOR OR RACE: Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Married

8. DATE OF BIRTH: July 7, 1915

9. AGE Last birthday 40 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY: own Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: Edward Mumford.

14. MOTHER'S MAIDEN NAME: Laldie Showell.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)

(If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. 212-12-3602

17. INFORMANT & ADDRESS: Isaah Armstrong Whaleyville

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

174X

IMMEDIATE CAUSE (A) Cancer of the uterus with widespread metastasis

ANTECEDENT CAUSE (S)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

DUE TO (B)

DUE TO (C)

INTERVAL BETWEEN ONSET AND DEATH: 18-24 mos.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3/29, 1955, to 8/8, 1955, that I last saw the deceased alive on 8/8, 1955, and that death occurred at 7:00 A.M., from the causes and on the date stated above.

SIGNATURE Leon M. Purdy Jr. M. D. ADDRESS Berlin, Md. DATE SIGNED 8-10-1955.

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial

DATE THEREOF 8/12/55

NAME OF CEMETERY OR CREMATORY Pollitt Chapel

LOCATION (City, town, or county) (State) Whaleyville, Md.

DATE REC'D BY LOCAL REGISTRAR 8/10/55

REGISTRAR'S SIGNATURE Helen F Hayward

24. FUNERAL DIRECTOR Peter Whaley ADDRESS Whaleyville, Md.

VS. A15—10-5

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18231

8227 CERTIFICATE OF DEATH

Reg. Dist. No. 350

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH:
COUNTY Worcester | MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Pocomoke | LENGTH OF STAY (in this place)
42 HOSPITAL OR INSTITUTION OR STREET ADDRESS 3-Fourth Street
00 Home

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Worcester
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN 3-Fourth Street 42
STREET ADDRESS (If rural give location) 1
Pocomoke City, Maryland

3. NAME OF DECEASED: (Type or Print) (First) John (Middle) Henry (Last) Colbourn

4. DATE OF DEATH: (Month) August (Day) 30 (Year) 1955

5. SEX: M.

6. COLOR OR RACE: C.

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: Oct. 24, 1893

9. AGE last birthday: 61 yrs. | IF UNDER 1 YEAR: Months | Days | IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John S. Colbourn

14. MOTHER'S MAIDEN NAME: Georgia Anna Robinson

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No | (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.: 213-01-7224

17. INFORMANT & ADDRESS: Nettie Colbourn, Pocomoke City, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

162X
Immediate cause (a) Exhaustion & Malnutrition — Interval Between Onset And Death: 2½ mths

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
(b) Bronchogenic Carcinoma. — 2 yrs.

DUE TO

(c)

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Cystitis.

19a. DATE OF OPERATION: | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURED While at Work ☐ Not While At Work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7/5, 19 55, to 8/30, 19 55, that I last saw the deceased alive on 8/30, 19 55, and that death occurred at 3:15 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Cecil A. Duvernay. ADDRESS 508 Fifth St Pocomoke DATE SIGNED 9/1/55

23. BURIAL, CREMATION, REMOVAL (Specify) Burial | DATE THEREOF 9/2/55 | NAME OF CEMETERY OR CREMATORY Greenlawn, Cem. | LOCATION (City, town, or county) (State) Berlin, Maryland

DATE REC'D BY LOCAL REGISTRAR Sept. 2, 1955 | REGISTRAR'S SIGNATURE Anne E. White | 24. FUNERAL DIRECTOR Edgar Mills to mail Cloak | ADDRESS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08233

! 8229

CERTIFICATE OF DEATH

Reg. Dist. No. 350

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-

1. PLACE OF DEATH:
COUNTY Worcester MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Home

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Worcester
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke, Md. X
STREET ADDRESS (If rural give location) R.F.D. 1

3. NAME OF DECEASED: (First) LOWELL (Middle) (Last) FOUNTAIN

4. DATE OF DEATH: (Month) August (Day) 16 (Year) 1955

5. SEX: male

6. COLOR OR RACE: Col.

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify):

8. DATE OF BIRTH: April 1, 1955

9. AGE last birthday yrs. 4 IF UNDER 1 YEAR Months 4 Days 15 IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —

10B. KIND OF BUSINESS OR INDUSTRY: Infant

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Fountain

14. MOTHER'S MAIDEN NAME: Annie Marshall

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)

(If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT & ADDRESS: Annie Marshall - Pocomoke, Md.

18. MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
571.0 IMMEDIATE CAUSE	(A) Exhaustion & Dehydration	4 days
ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	(B) DUE TO Acute Gastro enteritis	15 dys
	(C) Hydrocephalus (spastic)	4½ mths.
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.	Cerebral Palsy (Spastic)	4½ mths

19A. DATE OF OPERATION: 6-7 April '55

19B. MAJOR FINDINGS OF OPERATION: Hydrocephalus (internal)

20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7/2, 19 55, to 8/13, 19 55, that I last saw the deceased alive on 8/13, 19 55, and that death occurred at ..... M, from the causes and on the date stated above.

SIGNATURE Cecil A. Downey M. D. ADDRESS DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial

DATE THEREOF 8-17-55

NAME OF CEMETERY OR CREMATORY R.B. Wharton Memorial

LOCATION (City, town, or county) (State) Parksley Va.

DATE REC'D BY LOCAL REGISTRAR Aug. 20 1955

REGISTRAR'S SIGNATURE Anne E. White

24. FUNERAL DIRECTOR Edgar Wharton

ADDRESS New Church, Va.

9V45993V

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that th h certificate be executed within
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: WORCESTER — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BERLIN
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MD — b. COUNTY: WORCESTER.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BERLIN
d. STREET ADDRESS: R. F. D.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: LOUISE — Middle: GENETTO — Last: GRIFFIN

4. DATE OF DEATH: Month: AUG. — Day: 21 — Year: 1955

5. SEX: F.

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: OCT. 4, 1891

9. AGE (In years last birthday): 63 yrs.

IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: OWN HOME

11. BIRTHPLACE (State or foreign country): BERLIN MD

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JESSE TURNER

14. MOTHER'S MAIDEN NAME: ELLA TOWNSEND

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): NO / NO

16. SOCIAL SECURITY NO.: NO

17. INFORMANT: Address: MR. LEE GRIFFIN, BERLIN, MD. RFD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Edema Carcinoma of Ascending Colon
DUE TO (b): Generalized Metastasis & Marasmus
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 6 mo.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Operation for Removal Ca of Colostomy May 1955

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Month, Day, Year: Hour o. m. / p. m. — 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June, 1942, to August 21, 1955, that I last saw the deceased alive on Aug 21, 1955, and that death occurred at 6 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Fernando Tarkus M.D. ADDRESS (Street, city or town, state): Berlin, Md. DATE SIGNED:

PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify): Buried

22b. DATE THEREOF: AUG. 24 1959

22c. NAME OF CEMETERY OR CREMATORY: EVERGREEN

22d. LOCATION (City, town, or county) (State): BERLIN MD

23. FUNERAL DIRECTOR'S SIGNATURE: Thomas R. Burbage ADDRESS: Berlin Md.

24a. REC'D BY REGISTRAR DATE: APR 28 '59

24b. REGISTRAR'S SIGNATURE: Arthur E. Travers

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08234

8230 CERTIFICATE OF DEATH Reg. Dist. No. 353

1. PLACE OF DEATH:
COUNTY Worcester MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bishop RFD. | LENGTH OF STAY (In this place) Life
HOSPITAL OR INSTITUTION OR STREET ADDRESS —

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Worcester.
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bishop
STREET ADDRESS (If rural give location) RFD. 1

3. NAME OF DECEASED: (Type or Print) (First) Stella (Middle) Mae (Last) Hickman

4. DATE OF DEATH: (Month) Aug (Day) 11 (Year) 1955

5. SEX: Female | 6. COLOR OR RACE: White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married | 8. DATE OF BIRTH: April 27 | 9. AGE last birthday: 65 yrs. | IF UNDER 1 YEAR: Months, Days | IF UNDER 24 HRS.: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife | 10B. KIND OF BUSINESS OR INDUSTRY: own Home | 11. BIRTHPLACE (State or foreign country): Maryland | 12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James Tubbs | 14. MOTHER'S MAIDEN NAME: Mary Lueller

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) — | (If Yes, give war or dates of service) — | 16. SOCIAL SECURITY NO. — | 17. INFORMANT & ADDRESS: Mr. Joseph Hickman RFD Berlin Md

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

260X

IMMEDIATE CAUSE (A) Coronary atherosclerosis, acute pulmonary edema — INTERVAL BETWEEN ONSET AND DEATH: from 2 days

ANTECEDENT CAUSE (S)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

DUE TO (B) arteriosclerosis severe, Diabetic Gangrene — 1 year

DUE TO (C) Diabetes Mellitus — 15 years

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. old ununited hip fracture — 1 year

19A. DATE OF OPERATION: | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | 21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M. | 21E. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept. 1954, to Aug. 1955, that I last saw the deceased alive on ....., 19..., and that death occurred at ..... M, from the causes and on the date stated above.

SIGNATURE Robert A. Gentz M.D. | ADDRESS Berlin, Md. | DATE SIGNED 8/15/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | DATE THEREOF 8/14/55 | NAME OF CEMETERY OR CREMATORY Zion Church yard | LOCATION (City, town, or county) (State) Bishopville, Md.

DATE REC'D BY LOCAL REGISTRAR 8/13/55 | REGISTRAR'S SIGNATURE Mrs. D. Ky Bergen | 24. FUNERAL DIRECTOR Peter Whaley | ADDRESS Selbyville, Del.

VS. A15—10-

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08235

CERTIFICATE OF DEATH

8231

Reg. Dist. No. 353

1. PLACE OF DEATH: COUNTY Worcester MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Bishopville
LENGTH OF STAY (in this place) Life
HOSPITAL OR INSTITUTION OR STREET ADDRESS 00 —

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Worcester
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bishopville X
STREET ADDRESS (If rural give location) X

3. NAME OF DECEASED: (Type or Print) (First) Laura (Middle) E. (Last) Hudson

4. DATE OF DEATH: (Month) Aug (Day) 11 (Year) 1955

5. SEX: Female | 6. COLOR OR RACE: White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widow | 8. DATE OF BIRTH: Nov. 4, 1874 | 9. AGE last birthday 80 yrs. | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife | 10B. KIND OF BUSINESS OR INDUSTRY: own home | 11. BIRTHPLACE (State or foreign country): Delaware | 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Caleb Lynch | 14. MOTHER'S MAIDEN NAME: Julia Brown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) — (If Yes, give war or dates of service) | 16. SOCIAL SECURITY NO. — | 17. INFORMANT & ADDRESS: Mrs H.B. Morris Bishopville Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

241X

IMMEDIATE CAUSE (A) Pulmonary edema acute — 6 hours

ANTECEDENT CAUSE (S)

DISEASES OR CONDITIONS, IF any, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

DUE TO (B) Cor pulmonale, pulmonary emphysema — 3 yrs.

DUE TO (C) severe asthmatic bronchitis — 10 years

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. resultant emphysema

19A. DATE OF OPERATION: | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M. | 21E. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept. 1953, to Aug. 1955, that I last saw the deceased alive on August 10, 1955, and that death occurred at 4 A.M., from the causes and on the date stated above.

SIGNATURE Robert A. Grubb M.D. ADDRESS Berlin, Md. DATE SIGNED 8/11/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | DATE THEREOF 8/13/55 | NAME OF CEMETERY OR CREMATORY I.O.O.F. | LOCATION (City, town, or county) (State) Bishopville Md.

DATE REC'D BY LOCAL REGISTRAR 8/12/55 | REGISTRAR'S SIGNATURE Mrs. L. Ray Berger | 24. FUNERAL DIRECTOR ADDRESS Peter Healy Selbyville Del.

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15—10

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08236

8232 **CERTIFICATE OF DEATH** Reg. Dist. No. 351

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 5

1. PLACE OF DEATH: COUNTY Worcester MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Snow Hill
LENGTH OF STAY (in this place) 74 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS 08

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY Worcester
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Snow Hill
STREET ADDRESS (If rural give location) X

3. NAME OF DECEASED: (Type or Print) (First) Walter (Middle) (Last) Hudson

4. DATE OF DEATH (Month) Aug (Day) 9 (Year) 1955

5. SEX: Male | 6. COLOR OR RACE: White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single | 8. DATE OF BIRTH: April 16-1911 | 9. AGE last birthday 44/3/33 yrs. | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Mln.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Tailor | 10B. KIND OF BUSINESS OR INDUSTRY: Hatchery | 11. BIRTHPLACE (State or foreign country): Snow Hill | 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: William J. Hudson | 14. MOTHER'S MAIDEN NAME: Emma Rodney

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Yes | (If Yes, give war or dates of service) World War II | 16. SOCIAL SECURITY NO. 220-26-2819 | 17. INFORMANT & ADDRESS: Mrs Mary D Townsend, Snow Hill Md

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

420.1
IMMEDIATE CAUSE (A) Myocardial Infarction — 10 minutes
ANTECEDENT CAUSE (S)
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO
(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M. | 21E. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb 20, 1955, to Aug 9, 1955, that I last saw the deceased alive on Aug 9, 1955, and that death occurred at 8 30 P M, from the causes and on the date stated above.
SIGNATURE Thomas L. Jones, M.D. M. D. ADDRESS Snow Hill, Md. DATE SIGNED August 10, 1955

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | DATE THEREOF Aug 12/55 | NAME OF CEMETERY OR CREMATORY Episcopal Cemetery | LOCATION (City, town, or county) Snow Hill (State) Md

DATE REC'D BY LOCAL REGISTRAR Aug 12, 1955 | REGISTRAR'S SIGNATURE Elwyn E. Cooper | 24. FUNERAL DIRECTOR ADDRESS Elias E. Timms, Snow Hill, Md

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08237

8233

CERTIFICATE OF DEATH

Reg. Dist. No. 351

1. PLACE OF DEATH:
COUNTY Worcester MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Snow Hill
LENGTH OF STAY (in this place) 23 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS 60

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md COUNTY Worcester
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Snow Hill
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) Bessie (Middle) (Last) Marshall

4. DATE OF DEATH (Month) Aug. (Day) 29 (Year) 1955

5. SEX: Female

6. COLOR OR RACE: Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed

8. DATE OF BIRTH: Nov. 15-1885

9. AGE last birthday 69/9/14 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife

10B. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Newark N. C.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Ira Jones

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT & ADDRESS: Mr James E. Baxter, Snow Hill, Md

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

443X

IMMEDIATE CAUSE (A) Cerebral Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 2 days

ANTECEDENT CAUSE (S)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

DUE TO (B) Hypertensive Cardiovascular disease — 10 yrs

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug. 28, 1955, to Aug. 29, 1955, that I last saw the deceased alive on Aug. 29, 1955, and that death occurred at 1:00 P M, from the causes and on the date stated above.

SIGNATURE John R. LaMar M. D. ADDRESS Snow Hill DATE SIGNED 8-29-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial — DATE THEREOF Sept. 1 55 — NAME OF CEMETERY OR CREMATORY Baptist Cemetery — LOCATION (City, town or county) (State) Snow Hill, Md

DATE REC'D BY LOCAL REGISTRAR Sept 1, 55 — REGISTRAR'S SIGNATURE Glenn E. Cooper — 24. FUNERAL DIRECTOR Clay E. Timmons — ADDRESS Snow Hill Md

VS. A15 — 10 -

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

8234

08238

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 355

1. PLACE OF DEATH:
COUNTY Worcester MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Berlin
LENGTH OF STAY (in this place) 3 Hrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS RFD

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Delaware COUNTY
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Dover 46X-3
STREET ADDRESS (If rural, give location) Dover-Hartley Road

3. NAME OF DECEASED: (First) (Middle) (Last)	4. DATE OF DEATH (Month) (Day) (Year)
ROWE VON PLEASANTON	AUG. 11 1955

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
MALE	WHITE	MARRIED	APRIL 3, 1904	51 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
ROAD CONSTRUCTION CONT.	SELF-EMP.	DOVER DEL.	U.S.A.

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
JAMES PLEASANTON	MARTHA THOMPSON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT & ADDRESS:
No No	-	MRS. R. V. PLEASANTON, DOVER DEL

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		Interval Between Onset and Death
420.1 Immediate cause	(a) Acute Coronary Thrombosis	minutes
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	(b) DUE TO Coronary Atherosclerosis & Coronary Heart Disease	2 yrs
	(c) DUE TO Coronary Thrombosis - Hemorrhage	1 yr 2 days

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes ☐ No ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)

21d. TIME (Mouth) (Day) (Year) (Hour) OF INJURY M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE Herman A. Robbins M. D. CHIEF MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAM. ☒ DATE SIGNED 8/12/55

23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
BURIAL	8/15/55	Lakeside	Dover Del

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
8-13-55	Helen F Hayward	Emma A. Burbage	Berlin Md

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A - 5 - 53

8235

08239 Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 351

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY Worcester MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Snow Hill
LENGTH OF STAY (In this place) 2yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS Rural #2

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md COUNTY Worcester
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Snow Hill
STREET ADDRESS (If rural, give location) Rural #2

3. NAME OF DECEASED: (Type or Print) (First) Barbara (Middle) a. (Last) Shackley

4. DATE OF DEATH (Month) Aug (Day) 9 (Year) 1955

5. SEX: Female

6. COLOR OR RACE: Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: Nov. 4 1932

9. AGE last birthday: 2/9/5 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Salisbury

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Avery Shackley

14. MOTHER'S MAIDEN NAME: Sattie Copeland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT & ADDRESS: Mr Thomas Copeland, Snow Hill, Md Rural #2

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		Interval Between Onset and Death
Immediate cause 491X	(a) Asphyxiation	10 min.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	DUE TO (b) Bilateral Confluent Broncho pneumonia with purulent Bronchitis	2 days

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:

19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY? Yes ☒ No ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY

21c. (City or town) (County) (State)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M.

21e. INJURY OCCURRED While at work ☐ Not while at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE Robert W. Lamas M. D.
CHIEF MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAM. ☒
DATE SIGNED 8-10-55

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE THEREOF Aug. 11/55 | NAME OF CEMETERY OR CREMATORY Pitts Chapel | LOCATION (City, town, or county) Snow Hill (State) Md

DATE REC'D BY LOCAL REG. Aug 11, 55 | REGISTRAR'S SIGNATURE Elmer E. Cooper | **24. FUNERAL DIRECTOR** Elley E. Timmis | ADDRESS Snow Hill, Md

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08240 Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 350

1. PLACE OF DEATH:
COUNTY Worcester MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Pocomoke City (Rural) | LENGTH OF STAY (in this place) 3 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS Jones Farm 3 miles of Pocomoke

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md COUNTY Worcester
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Rural — Pocomoke City Md
STREET ADDRESS (If rural give location) 3 miles north from Pocomoke to good-will

3. NAME OF DECEASED: (First) Henry (Middle) (Last) Taylor

4. DATE OF DEATH (Month) Aug (Day) 22 (Year) 1955

5. SEX: M

6. COLOR OR RACE: C

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): M

8. DATE OF BIRTH: (Mo.-Day) DK (Year) 1882

9. AGE Last birthday: 73 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Farm

11. BIRTHPLACE (State or foreign country): Don't Know

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Levin Taylor

14. MOTHER'S MAIDEN NAME: Mary Purnell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) No

16. SOCIAL SECURITY NO.: None (Veteran)

17. INFORMANT & ADDRESS: Sister Mrs. Nora E. Taylor - Stockton Md RFD

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: (Interval Between Onset and Death)

420.1
Immediate cause (a) Angina Pectoris — short

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause (stating underlying cause last)
DUE TO (b) Coronary disease — 3 years +
DUE TO (c)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Performed heavy work for 2 or 3 hours before death

19a. DATE OF OPERATION:

19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY

21c. (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21e. INJURY OCCURRED While at work ☐ Not while at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE S. E. Bartosiewicz M. D.

CHIEF MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
ASSISTANT MEDICAL EXAM. ☐

DATE SIGNED 8/27/55

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	8-27-55	Pt. Hope	Pocomoke Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Sept. 2, 1955	Anne E. White	Edgar Wharton - new Church	

PLEASE WRITE PLAINLY, WITH UNFA... age is especially important. Phy... please write the cause in detail, and legibly.

24 hours after death.

e deat